part #1

INTITIAL NOTICE OF CLAIM FOR DAMAGES AGAINST THE STATE OF NEW JERSEY

FORWARD TO: TORT AND CONTRACT UNIT, CLAIMS SEVICE SECTION
DEPARTMENT OF THE TREASURY, BUREAU OF RISK MGT.
CN 620
TRENTON, NEW JERSEY 08625
PHONE: (609) 292-4347

* FORM MUST BE FILED WITHIN 90 DAYS OF THE ACCIDENT OR YOU MAY FORFEIT YOUR RIGHT

1. Michael J. Clouso sbi #880700-B — NAME OF CLAIMANT
   Northern State Prison — STREET ADDRESS
   8-23-1974 — DATE OF BIRTH
   po box 2300, Newark N.J. 07114 — CITY / STATE / ZIP CODE
   973-857-3740 — DAYTIME PHONE#/CONTANCT
   154-72-4482 — SOCIAL SECURITY NUMBER

2. IF IT IS REQUESTED THAT NOTICES BE SENT TO A PERSON OTHER THAN THE CLAIMANT, SUCH AS YOUR ATTORNEY, PLEASE SEND NOTICES TO:

   NAME OF PERSON — STREET ADDRESS
   TELEPHONE NUMBER — CITY / STATE / ZIP CODE

   RELATIONSHIP TO CLAIMANT: ☒ ATTORNEY ☐ OTHER _____
   I am forwarding this information/documents/papers to

3. CIRCUMSTANCES REGARDING THE OCCURRENCE OR ACCIDENT:

   Mon 8-6-2018 Approx 16:45 — DATE AND TIME
   Back of Transport Van D.O.C. — LOCATION
   Weistletown B N.J. — CITY / STATE

4. DESCRIBE THE ACCIDENT OR OCCURRENCE:

   on said date I was being transferred from Mid State Corr. Facility to Garden State Youth Corr. Fac. as a result of Corr off. Rookie driver who was driving erratic and dangerously had to stop short, I tumbled over and hit my head & received permanent disfigurement and injury.

5. STATE THE NAME AND ADDRESS OF ALL WITNESSES TO ABOVE OCCURRENCE:

Corr. Off Rookie (African American, 25 yrs old), driving, Sgt. Clemens and all recieving staff at G.S.C.F. Dr. Myra/Nursing staff. Medical staff at Northern State prison.

6. STATE THE NAMES AND ADDRESSES OF EACH STATE AGENCY AND EACH STATE EMPLOYEE WHOM YOU CLAIM CAUSED YOUR DAMAGES OR INJURIES.

Corr. Off. Rookie Midstate (African American, 25 yrs of age) Sgt. Clemens and all recieving personel at G.S.C.F. Medical Staff at G.S.C.F. Dr. Myra/Nursing staff Northern State prison Medical Staff, Custody Staff

7. STATE THE NAME AND ADDRESS OF ALL OTHER PERSONS, COMPANIES, OR GOVERNMENTAL AGENCIES WHICH YOU CLAIM ARE RESPONSIBLE FOR YOUR INJURIES OR DAMAGES.

Department of Corrections, Midstate/Northern State prisons. Rutgers Medical staff/University

8. BRIEFLY DESCRIBE THE INJURY, DAMAGES AND LOSSES INCURRED BY YOU.

Scare on head 1½ inches square, one and a half inches square torn flesh. Permanent disfigurement. Nerve damage right side of neck. Continued pain.

9. GIVE THE AMOUNT THAT YOU CLAIM IN DAMAGES: $ 200,000.00 Two Hundred Thousand Dollars

GIVE THE BASIS FOR CALCULATION OF THE ABOVE DAMAGES:

Permanent Disfigurement. Did'nt see Medical for 17 hours... permanent physical pain. Did'nt get physical therapy for 60 ... psychological & emotional pain. Being under educated I am only qualified to work manual labor. Hard physical labor. Because of the nerve damage I may not be able to work. Should be much more because ... [illegible]

I certify that the foregoing statements made by me are true. I am aware that if any statement made herein is willfully false or fraudulent, i am subject to punishment as provided by law.

Mod. Date: 10-22-2018

Michael A. Clouse
CLAIMANT OR PERSON FILING ON BEHALF OF CLAIMANT

Michael A. Clouse

Part #2

INTITIAL NOTICE OF CLAIM FOR DAMAGES AGAINST THE STATE OF NEW JERSEY

FORWARD TO: TORT AND CONTRACT UNIT, CLAIMS SEVICE SECTION
DEPARTMENT OF THE TREASURY, BUREAU OF RISK MGT.
CN 620
TRENTON, NEW JERSEY 08625
PHONE: (609) 292-4347

* FORM MUST BE FILED WITHIN 90 DAYS OF THE ACCIDENT OR YOU MAY FORFEIT YOUR RIGHT

1. Michael J. Cuso Sbi# 880700-B — NAME OF CLAIMANT
   Northern State prison — STREET ADDRESS
   8-23-1974 — DATE OF BIRTH
   PO Box 2300, Newark NJ 07114 — CITY / STATE / ZIP CODE
   973-854-3740 — DAYTIME PHONE#/CONTANCT
   154-72-4482 — SOCIAL SECURITY NUMBER

2. IF IT IS REQUESTED THAT NOTICES BE SENT TO A PERSON OTHER THAN THE CLAIMANT, SUCH AS YOUR ATTORNEY, PLEASE SEND NOTICES TO:

   NAME OF PERSON
   STREET ADDRESS
   TELEPHONE NUMBER
   CITY / STATE / ZIP CODE

   RELATIONSHIP TO CLAIMANT: ☑ ATTORNEY ☐ OTHER
   Sent forwarding this information/documents/papers to file.

3. CIRCUMSTANCES REGARDING THE OCCURRENCE OR ACCIDENT:
   8-28-2018 / 17:00 hrs — DATE AND TIME
   Check Camera
   D-1-West cell 202 — LOCATION
   Newark NJ 07114 — CITY / STATE

4. DESCRIBE THE ACCIDENT OR OCCURRENCE:
   Was punched in face my Corr. Off. Northern State Prison.

5. STATE THE NAME AND ADDRESS OF ALL WITNESSES TO ABOVE OCCURRENCE:
Camera/Video: Inmate Juan Reyes, Trenton SID, Northern State.

6. STATE THE NAMES AND ADDRESSES OF EACH STATE AGENCY AND EACH STATE EMPLOYEE WHOM YOU CLAIM CAUSED YOUR DAMAGES OR INJURIES.
Corr Off Diaz, Northern State prison

7. STATE THE NAME AND ADDRESS OF ALL OTHER PERSONS, COMPANIES, OR GOVERNMENTAL AGENCIES WHICH YOU CLAIM ARE RESPONSIBLE FOR YOUR INJURIES OR DAMAGES.
Northern State Prison

8. BRIEFLY DESCRIBE THE INJURY/DAMAGES AND LOSSES INCURRED BY YOU.
I was punched in face for no reason what so ever other then the guy felt like doing it.

9. GIVE THE AMOUNT THAT YOU CLAIM IN DAMAGES: $ Figure is included in first part $200,000.00 Two Hundred Thousand Dollars
GIVE THE BASIS FOR CALCULATION OF THE ABOVE DAMAGES:
It's not part of the job of a Corr Officer to punch inmates at anytime. It should be part of Professionalism that is rampant in all of N.J. Law Enforcement. Psychological Damage... And they need to be held responsible for their actions

I certify that the foregoing statements made by me are true. I am aware that if any statement made herein is willfully false or fraudulent, i am subject to punishment as provided by law.

Date: 10-22-2018

CLAIMANT OR PERSON FILING ON BEHALF OF CLAIMANT

Part # 3

INTITIAL NOTICE OF CLAIM FOR DAMAGES AGAINST THE STATE OF NEW JERSEY

FORWARD TO: TORT AND CONTRACT UNIT, CLAIMS SEVICE SECTION
DEPARTMENT OF THE TREASURY, BUREAU OF RISK MGT.
CN 620
TRENTON, NEW JERSEY 08625
PHONE: (609) 292-4347

* FORM MUST BE FILED WITHIN 90 DAYS OF THE ACCIDENT OR YOU MAY FORFEIT YOUR RIGHT

1. Michael J. Clauso — NAME OF CLAIMANT
Northern State Prison — STREET ADDRESS
8-23-74 — DATE OF BIRTH
P.O. Box 2300 Newark, N.J. 07114 — CITY STATE ZIP CODE
973-857-3740 — DAYTIME PHONE#/CONTANCT
154-72-4482 — SOCIAL SECURITY NUMBER

2. IF IT IS REQUESTED THAT NOTICES BE SENT TO A PERSON OTHER THAN THE CLAIMANT, SUCH AS YOUR ATTORNEY, PLEASE SEND NOTICES TO:

NAME OF PERSON — STREET ADDRESS
TELEPHONE NUMBER — CITY STATE ZIP CODE

RELATIONSHIP TO CLAIMANT: ☒ ATTORNEY ☐ OTHER _____
Also Forwarding him this information, papers, documents....

3. CIRCUMSTANCES REGARDING THE OCCURRENCE OR ACCIDENT:
Sat. Sept 1st 2018 / 9-1-18 — DATE AND TIME
S.U. in Northern State Prison — LOCATION
Newark N.J. — CITY STATE

4. DESCRIBE THE ACCIDENT OR OCCURRENCE:
Taken to S.U. @ N.S.P., Sgt. Colloghs, S.C.O. Cook, S.C.O. Morale was ordered to strip in the cell, And was told to lay face down, Naked, with my hands behind my head, on a dirty Mat. At this point I was Already Attacked by A.D. S.C.O. for no reason, So I thought I better do it. The whole order/was degrading, demoralizing, dehumanizing...

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5. STATE THE NAME AND ADDRESS OF ALL WITNESSES TO ABOVE OCCURRENCE:
Sgt. Collough
S.C.O. Cook
S.C.O. Morales - Gave the order
S.C.O. Caucasian - 6

6. STATE THE NAMES AND ADDRESSES OF EACH STATE AGENCY AND EACH STATE EMPLOYEE WHOM YOU CLAIM CAUSED YOUR DAMAGES OR INJURIES.
Department of Corrections - New Jersey - Maybe some of these State Corr. Off. Suffer from the MachiaVelli Effect this S.C.O Morales A.B.U. Ehrors, that Atrocity that happened to the P.O.W.s in Iraq.

7. STATE THE NAME AND ADDRESS OF ALL OTHER PERSONS, COMPANIES, OR GOVERNMENTAL AGENCIES WHICH YOU CLAIM ARE RESPONSIBLE FOR YOUR INJURIES OR DAMAGES.
N/A

8. BRIEFLY DESCRIBE THE INJURY, DAMAGES AND LOSSES INCURRED BY YOU.
Something is Not right in My brain After that. Being A Child hood PTSD Suffer it seemed sexual and Tastely out of order, right after that I get Kicked of- The Mental Health roster.

9. GIVE THE AMOUNT THAT YOU CLAIM IN DAMAGES: $ 500,000.00
Five Hundred Thousand U.S. dollars / Not to be included in Any other Area
GIVE THE BASIS FOR CALCULATION OF THE ABOVE DAMAGES:
DeHumanization
DeGradacion
DeMoralizing

I certify that the foregoing statements made by me are true. I am aware that if any statement made herein is willfully false or fraudulent, i am subject to punishment as provided by law.

Thurs
Date: 11-8-2018

Michael James Causo
CLAIMANT OR PERSON FILING ON BEHALF OF CLAIMANT

Michael James Causo

part II

INTITIAL NOTICE OF CLAIM FOR DAMAGES AGAINST THE STATE OF NEW JERSEY

FORWARD TO: TORT AND CONTRACT UNIT, CLAIMS SEVICE SECTION
DEPARTMENT OF THE TREASURY, BUREAU OF RISK MGT.
CN 620
TRENTON, NEW JERSEY 08625
PHONE: (609) 292-4347

* FORM MUST BE FILED WITHIN 90 DAYS OF THE ACCIDENT OR YOU MAY FORFEIT YOUR RIGHT

1. Michael J. Cluso — NAME OF CLAIMANT
8-23-74 — DATE OF BIRTH
973-857-3740 — DAYTIME PHONE#/CONTANCT
Northern State Prison — STREET ADDRESS
PO Box 2300 — [redacted] Newark, N.J. 07114 — CITY / STATE / ZIP CODE
154-72-4482 — SOCIAL SECURITY NUMBER

2. IF IT IS REQUESTED THAT NOTICES BE SENT TO A PERSON OTHER THAN THE CLAIMANT, SUCH AS YOUR ATTORNEY, PLEASE SEND NOTICES TO:

NAME OF PERSON
STREET ADDRESS
TELEPHONE NUMBER
CITY STATE ZIP CODE

RELATIONSHIP TO CLAIMANT: ☒ ATTORNEY ☐ OTHER
I am Forwarding this information/documents/papers to him

3. CIRCUMSTANCES REGARDING THE OCCURRENCE OR ACCIDENT:

presentation going — DATE AND TIME
Northern State Prison — LOCATION
Newark N.J. — CITY STATE

4. DESCRIBE THE ACCIDENT OR OCCURRENCE:

I've complained to no Avail, About the inconsistent Medical care/ And practice Here At this prison, half of the Staff Don't even speak proper english. You tell them I got this Medical problem Don't have this Medication. They Say "fill out Slip" How many times you gotta fill out slip?

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5. STATE THE NAME AND ADDRESS OF ALL WITNESSES TO ABOVE OCCURRENCE:
Social Worker spoke with on unit C-1-E/C-3-W
on sept. 30th 2018/ on Nov 7th 2018.
[illegible]
Anikuol Shah Rpt nov 7th 2018

6. STATE THE NAMES AND ADDRESSES OF EACH STATE AGENCY AND EACH STATE EMPLOYEE WHOM YOU CLAIM CAUSED YOUR DAMAGES OR INJURIES.
Depart-ment of Corrections, New Jersey
Rutgers/ University Medical care giver

7. STATE THE NAME AND ADDRESS OF ALL OTHER PERSONS, COMPANIES, OR GOVERNMENTAL AGENCIES WHICH YOU CLAIM ARE RESPONSIBLE FOR YOUR INJURIES OR DAMAGES.

foot 9 / 8. BRIEFLY DESCRIBE THE INJURY, DAMAGES AND LOSSES INCURRED BY YOU.
I Make the calculation based on the fact that I turned 44 years of age, 2 months ago, that I'm an American Citizen, I've been in pain since the 6th of August, was Already recieving Medical Attion for this injury, but this prison is not helping the problem.

for #8

9. GIVE THE AMOUNT THAT YOU CLAIM IN DAMAGES: $ 100,000.00
— ONE Hundred Thousand U.S. dollars —

GIVE THE BASIS FOR CALCULATION OF THE ABOVE DAMAGES:
Pain and suffering, inadequet medical care, due to lack of attentiveness, Malpractice incompetence Negligence. Can't get KOP'S. Can't get to Medical for Clearence from Staff infection. To go back to therapy This amount is seperate from previously filed, for Accident

I certify that the foregoing statements made by me are true. I am aware that if any statement made herein is willfully false or fraudulent, i am subject to punishment as provided by law.

Date: Thurs, 11-8-2018

Michael James Clauso
CLAIMANT OR PERSON FILING ON BEHALF OF CLAIMANT

Michael James Clauso

Portht #5

INTITIAL NOTICE OF CLAIM FOR DAMAGES AGAINST THE STATE OF NEW JERSEY

FORWARD TO: TORT AND CONTRACT UNIT, CLAIMS SEVICE SECTION
DEPARTMENT OF THE TREASURY, BUREAU OF RISK MGT.
CN 620
TRENTON, NEW JERSEY 08625
PHONE: (609) 292-4347

* FORM MUST BE FILED WITHIN 90 DAYS OF THE ACCIDENT OR YOU MAY FORFEIT YOUR RIGHT

1. Michael J. Clauso 880700-B
NAME OF CLAIMANT

8-23-1974
DATE OF BIRTH

973-857-3740
DAYTIME PHONE#/CONTANCT

Northern State prison
STREET ADDRESS

Newark N.J. 07114
CITY STATE ZIP CODE

154-72-4482
SOCIAL SECURITY NUMBER

2. IF IT IS REQUESTED THAT NOTICES BE SENT TO A PERSON OTHER THAN THE CLAIMANT, SUCH AS YOUR ATTORNEY, PLEASE SEND NOTICES TO:

NAME OF PERSON

STREET ADDRESS

TELEPHONE NUMBER

CITY STATE ZIP CODE

RELATIONSHIP TO CLAIMANT: ☒ ATTORNEY ☐ OTHER ______

I will forward these copys to him.

3. CIRCUMSTANCES REGARDING THE OCCURRENCE OR ACCIDENT:

4-28-2019
DATE AND TIME

Cell 420T/C-3-W @ N.S.P.
LOCATION

Newark N.J.
CITY STATE

4. DESCRIBE THE ACCIDENT OR OCCURRENCE:

My Quran was destroyed by water for no apparent reason by Corr. Off @ N.S.P. Lewin, @ the start of Ramadan and he stated I was a stupid white mother fucker as you must be able to tell these matters are on going.

5. STATE THE NAME AND ADDRESS OF ALL WITNESSES TO ABOVE OCCURRENCE:
all of C-3-W

6. STATE THE NAMES AND ADDRESSES OF EACH STATE AGENCY AND EACH STATE EMPLOYEE WHOM YOU CLAIM CAUSED YOUR DAMAGES OR INJURIES.
State Correctional Officer Lewis @ Northern State Prison.

7. STATE THE NAME AND ADDRESS OF ALL OTHER PERSONS, COMPANIES, OR GOVERNMENTAL AGENCIES WHICH YOU CLAIM ARE RESPONSIBLE FOR YOUR INJURIES OR DAMAGES.

8. BRIEFLY DESCRIBE THE INJURY, DAMAGES AND LOSSES INCURRED BY YOU.
The Harmed is Mental Psychological, I've been discriminated against, being mistreated in a mostly all African race prison, profiled because of my look

9. GIVE THE AMOUNT THAT YOU CLAIM IN DAMAGES: $500,000.00 U.S. dollars

GIVE THE BASIS FOR CALCULATION OF THE ABOVE DAMAGES:
I've been made to feel dehumanized, I've been put off my religion, [illegible]

I certify that the foregoing statements made by me are true. I am aware that if any statement made herein is willfully false or fraudulent, i am subject to punishment as provided by law.

Date: 6-3-2019

Michael J. Osuo
CLAIMANT OR PERSON FILING ON BEHALF OF CLAIMANT

Michael James Osuo

part # [redacted] 6

INITIAL NOTICE OF CLAIM FOR DAMAGES AGAINST THE STATE OF NEW JERSEY

FORWARD TO: TORT AND CONTRACT UNIT, CLAIMS SEVICE SECTION
DEPARTMENT OF THE TREASURY, BUREAU OF RISK MGT.
CN 620
TRENTON, NEW JERSEY 08625
PHONE: (609) 292-4347

* FORM MUST BE FILED WITHIN 90 DAYS OF THE ACCIDENT OR YOU MAY FORFEIT YOUR RIGHT

1. Michael A. Claud — NAME OF CLAIMANT
8-23-1974 — DATE OF BIRTH
973-857-3[redacted]40 — DAYTIME PHONE#/CONTANCT
Northern State Prison — STREET ADDRESS
Newark N.J. 07114 — CITY STATE ZIP CODE
154-72-4482 — SOCIAL SECURITY NUMBER

2. IF IT IS REQUESTED THAT NOTICES BE SENT TO A PERSON OTHER THAN THE CLAIMANT, SUCH AS YOUR ATTORNEY, PLEASE SEND NOTICES TO:

NAME OF PERSON
STREET ADDRESS
TELEPHONE NUMBER
CITY STATE ZIP CODE

RELATIONSHIP TO CLAIMANT: ☒ ATTORNEY ☐ OTHER _____

I will forward these copys to him

3. CIRCUMSTANCES REGARDING THE OCCURRENCE OR ACCIDENT:

[redacted] 5-23-2019 — DATE AND TIME
Law Library @ N.S.P. — LOCATION
Newark N.J. — CITY STATE

4. DESCRIBE THE ACCIDENT OR OCCURRENCE:

On said date State Corr. Off. McGee @ N.S.P. Law Library post, was told 'I'll punch you in the face cracker'

5. STATE THE NAME AND ADDRESS OF ALL WITNESSES TO ABOVE OCCURRENCE:
All of people at Law Library on said date.

6. STATE THE NAMES AND ADDRESSES OF EACH STATE AGENCY AND EACH STATE EMPLOYEE WHOM YOU CLAIM CAUSED YOUR DAMAGES OR INJURIES.
State Correctional Officer McGee @ N.S.P.

7. STATE THE NAME AND ADDRESS OF ALL OTHER PERSONS, COMPANIES, OR GOVERNMENTAL AGENCIES WHICH YOU CLAIM ARE RESPONSIBLE FOR YOUR INJURIES OR DAMAGES.

8. BRIEFLY DESCRIBE THE INJURY, DAMAGES AND LOSSES INCURRED BY YOU.
Psychological, Already included in part #7.

9. GIVE THE AMOUNT THAT YOU CLAIM IN DAMAGES: $500,000.00 U.S. dollars

GIVE THE BASIS FOR CALCULATION OF THE ABOVE DAMAGES:
The Amount is to cover all damages incurred by the Corr. Off. Staff @ N.S.P. These are gross Civil Rights Violations and 8C: Violations.

I certify that the foregoing statements made by me are true. I am aware that if any statement made herein is willfully false or fraudulent, i am subject to punishment as provided by law.

Date: 6-3-2019

CLAIMANT OR PERSON FILING ON BEHALF OF CLAIMANT

Northern State Prison-Main
PO Box 2300 Newark, NJ
Fax:

MICHAEL J. CLAUSO
Male DOB:08/23/1974 Booking #:1155878 SBI:000880700B
Ins: NJDOCIC (NJDOCIP)

06/20/2019 - Consultation Report: NEUROSURGERY CONSULTATION
Provider: Denise Johnson, NP
Location of Care: NJ Department of Corrections

NEUROSURGERY CONSULTATION

06/20/2019

RE: MICHAEL CLAUSO
DOB: 08/23/1974
SBI#: 000880700B
Ordering Provider: cmsjo65

This inmate was evaluated at the clinic on June 20, 2019. He complained of neck pain with radiation to his left arm. He attributes this to a motor vehicle accident where he struck his head and was thrown to the floor.

On examination, there is limited range of motion of the cervical spine in all directions secondary to discomfort. I do find slight weakness of the triceps muscle on the left as compared to the right. The remaining muscle groups are of normal strength.

I personally reviewed an MR scan of his cervical spine and see an osteophyte at the C6-C7 level which is off to the left and causing encroachment at the exiting nerve root at that level.

It is my impression that he has cervical radiculopathy.

I suggest a referral to Dr. Ibrahim to evaluate for a cervical epidural steroid injection. If he derives no improvement from this, then a referral to the GNI Neurosurgical Group to explore surgical options.

Francis J. Pizzi, MD

mts/2188294/31

Electronically Signed by Denise Johnson, NP on 06/26/2019 at 4:13 PM